LEVEL OF CARE DETERMINATION FOR ICF/MR

NAME _____ **ID** _____ **DOB** _____

1. Person has: (at least one of the following)

   a) MR: _____Yes _____No

   b) Related Disabilities: _____Yes _____No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

AND

2. Supervision is necessary due to: (at least one of the following)

   Impaired judgment/limited capabilities _____ Yes _____ No

   Behavior problems _____ Yes _____ No

   Abusiveness _____ Yes _____ No

   Assaultiveness _____ Yes _____ No

   Drug effects/medical monitorship _____ Yes _____No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

AND

3. Services are needed for: (at least one of the following)

   a) acquisition of behaviors necessary to function with as much self determination and independence as possible _____ Yes _____ No

   b) prevention or deceleration of regression or loss of current optimal functional status. _____ Yes _____ No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

APPROVED FOR ICF/MR LEVEL OF CARE _____ Yes _____ No

_____Initial Determination _____Annual Recertification _____Other (specify)

_____ _____
Signature/Title Date